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# Patterns of Care Given Migrant Workers in Utah by Private Physicians and Clinics

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HEALTH SERVICES for migrant workers must focus on the specific problems of this population—poverty, substandard housing, social isolation, and seasonal migration. Although not usually considered primarily health issues, these problems do contribute to disease and hinder health maintenance. Until they are recognized and dealt with, health care cannot be expected to receive a high priority in the migrant community.

Poverty is an obvious deterrent to obtaining health care. The 1971 Manpower Report of the President describes a typical migrant head of household as working only 32 weeks a year for annual earnings of \$1,813 (1). When his wife and children also work, the combined family income averages

\$3,350. Consequently, any health care program for migrants must make provision for payments either from the government or from private sources, for without such a subsidy health care is a luxury these people cannot afford except in a dire emergency.

Cultural isolation is another barrier limiting the migrant's opportunities to receive adequate health care. He may be largely ignorant of modern health standards and indicators of disease, ignoring symptoms until they reach crisis proportions, or he may hold stereotypic aspirations for a kind of medical care that is associated with an affluent lifestyle. Even when faced with a critical medical situation, access to the proper services may be virtually impossible for the rural worker who lacks transportation, linguistic skills, and specific information about the location and organization of health facilities.

Because health services for migrant workers require more than a concern for the treatment of symptoms, many factors must be assessed before a program that will meet their needs can be established. Only with a comprehensive, integrated approach can both the acute-care and long-term needs of this population be met.

Migrant health programs are often seasonal improvisations thrown together each year without the

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systematic planning necessary for realization of their potential benefits. The development of a program that will provide comprehensive, high-quality care requires examining the methods of delivering services already established for the nonmigrant population to determine which is the most appropriate and, at the same time, has the highest cost effectiveness.

When planning begins, such questions as these must be considered: What is the relative value of providing general primary care for acute, often self-limited, episodes of illness in comparison with disease-specific programs that could make significant improvements in the overall health of the migrant community, such as the fitting of eyeglasses, correction of anemia, or immunizations? To what extent should prevention be stressed? Should cost effectiveness be the main criterion for allocating resources? Should the delivery of medical care be part of a system that uses current medical knowledge as a tool for promoting social change (2)?

If the planners decide to provide more than episodic primary care, certain steps seem obvious such as holding clinics in the evenings, providing aides who speak the migrant's language, and establishing outreach programs. Yet each of these steps adds to the cost of an already expensive program.

Utah's experience may provide some perspective on these considerations. The State has a migrant population estimated at approximately 15,000, most of whom are agricultural farmworkers. Their stay in Utah extends from the beginning of April

through the end of October. To determine patterns of use and cost effectiveness, we analyzed the services provided by private physicians and by special health clinics to migrant workers during the 1973 season. The clinics were sponsored by the Utah Migrant Council and funded by grants from the U.S. Department of Health, Education, and Welfare.

### Methods

Data were obtained from 1,303 clinic-contact reports itemizing the services delivered at specially held clinics for the migrant workers and 322 physician's service vouchers describing the private care. The same geographic areas, as well as the same time period, were represented in the data from the two sources. Private physicians completed a voucher for each patient visit, requesting reimbursement from the migrant council for their services. The vouchers were distributed by community health workers to all migrants who expressed a need for medical care. A similar form was completed for each visit to the migrant clinics. These clinics were held regularly during the evenings in each migrant area and were staffed by physicians and supportive personnel working in conjunction with field health workers. The migrants were free to choose either source of care.

To examine patterns of utilization, we compared the age and sex distributions and the types of health problems of the two groups of patients. To assess the cost effectiveness of the care, we studied three factors: cost per visit, the number of health problems identified per visit, and the disposition of the

Figure 1. Percentage distribution by age and sex of migrant patients seen by private physicians and health clinic in Utah.

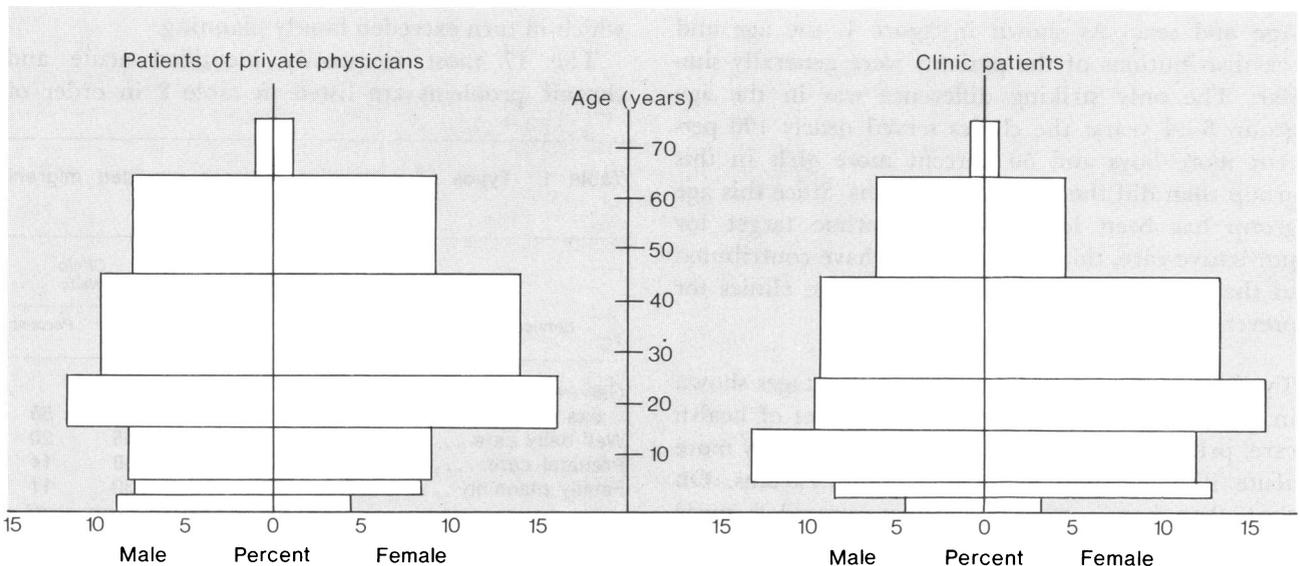
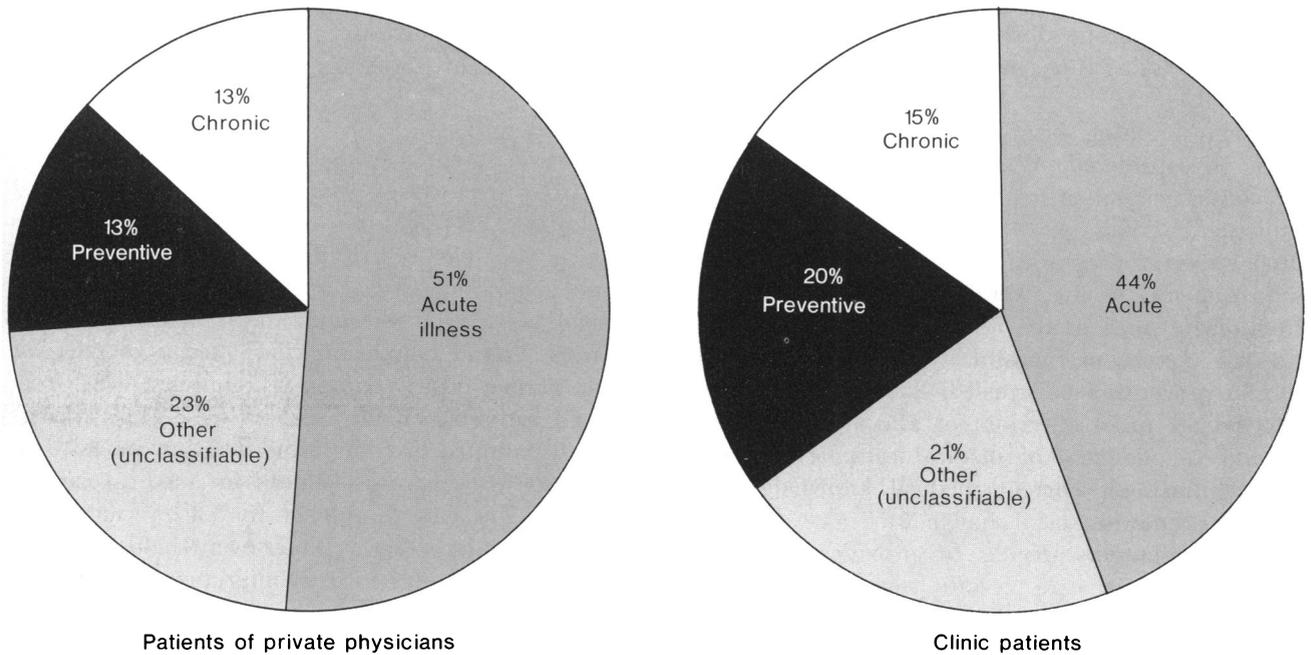


Figure 2. Percentage distribution of visits to private physicians and clinics according to major type of care given.



Note: Percentages based on count of visits regardless of number of visits made per patient

health problems. Cost data for the care given by private physicians were taken directly from the vouchers submitted to the Utah Migrant Council; clinic costs were calculated by prorating all costs directly incurred in the actual provision of services and related activities.

**Results**

**Age and sex.** As shown in figure 1, the age and sex distributions of the patients were generally similar. The only striking difference was in the age group 5-14 years: the clinics served nearly 100 percent more boys and 50 percent more girls in this age group than did the private physicians. Since this age group has been identified as a prime target for preventive care, this difference may have contributed to the higher percentage of visits to the clinics for preventive care.

**Types of care.** According to the percentages shown in figure 2 for the three major categories of health care, private physicians treated proportionately more acute illnesses than did the clinic physicians. On the other hand, clinic physicians provided more preventive services. These major categories were

further examined to determine the specific types of preventive services provided and the specific acute and chronic conditions treated.

Table 1 shows that about one-half of the preventive services were general physical examinations. The proportions of prenatal and well-baby visits were roughly equal for the two groups of patients. Well-baby care exceeded pregnancy monitoring, which in turn exceeded family planning.

The 17 most frequently identified acute and chronic problems are listed in table 2 in order of

Table 1. Types of preventive services provided migrant patients in Utah

Service	Visits to private physicians		Clinic visits	
	Number	Percent	Number	Percent
General physical examination	19	44	148	55
Well-baby care	14	33	55	20
Prenatal care	4	9	38	14
Family planning	6	14	30	11
Total	43	100	271	100

decreasing overall frequency. They account for 51 percent of all diagnoses. "Streptococcal" pharyngitis, representing about 7 percent of the problems, occurred more frequently than viral upper respiratory infections. (The diagnosis of streptococcal infection was a clinical one and does not necessarily connote culture-proved infection.) Pharyngitis and upper respiratory infections together accounted for about 14 percent of all diagnoses. Minor trauma was the next most frequent single problem (5 percent). Dermatitis and bacterial skin infection combined accounted for 6 percent of the problems noted. Diarrhea and influenza syndrome together accounted for 5 percent, making some form of gastrointestinal upset the third most common health problem among these migrants. All infectious diseases together made up at least a third of the diagnoses.

**Cost-effectiveness factors.** The number of acute and chronic health problems identified per visit averaged 1.06 for the clinics and 1.02 for the private physicians. The difference is so small that it leaves an overall impression of one problem per visit re-

gardless of the type of provider. Patients made return visits more frequently to the clinics (39 percent of the visits), than they did to the private physicians (32 percent).

A comparison of the services provided in meeting the migrants' health problems (table 3) showed that private physicians gave injections as often as they wrote prescriptions, whereas the clinic physicians gave injections much less frequently than they prescribed medicines. The clinics provided counseling services twice as often as did the private physicians, and they referred patients to other sources of care 10 times as often.

The costs of the two sources of care were as follows:

Private physicians:
Total fees paid = \$3,717
Total number of visits = 322
Average cost per visit = \$11.54
Migrant council health clinics:
Total operating cost = \$24,954
Total number of visits = 1,303
Average cost per visit = \$19.15
Total number of clinic sessions = 141
Average number of visits per clinic session = 9.25
Average cost per clinic session = \$177

Table 2. Most common acute and chronic health problems identified among migrant patients in Utah

Problem	Identified by —			
	Private physicians		Clinics	
	Number	Percent <sup>1</sup>	Number	Percent <sup>1</sup>
Pharyngitis or tonsillitis ...	48	14	76	6
Viral upper respiratory infection .....	12	4	102	7
Minor trauma .....	14	4	83	6
Dermatitis .....	6	2	69	5
Otitis media .....	12	4	35	3
Bacterial skin infection ...	8	2	42	3
Diarrhea .....	9	3	37	3
Influenza syndrome .....	8	2	28	2
Musculoskeletal aches and pains .....	8	2	45	3
Bronchitis .....	14	4	16	1
Abdominal pain, etiology unknown .....	8	2	26	2
Essential hypertension ...	6	2	32	2
Iron deficiency anemia ...	5	2	25	2
Urinary tract infection ...	6	2	15	1
Low back pain .....	5	2	22	2
Vaginitis or cervicitis .....	7	2	18	1
Hay fever or other allergy ..	4	1	24	2
<b>Total .....</b>	<b>180</b>	<b>54</b>	<b>695</b>	<b>50</b>
<b>Total, all acute and chronic problems ..</b>	<b>333</b>	<b>100</b>	<b>1,377</b>	<b>100</b>

<sup>1</sup> Of all acute and chronic problems identified.

The cost of operating the clinics was estimated on the basis of the following detailed accounting of expenditures:

Category	Cost
Physicians:	
Residents <sup>1</sup> —329¼ hours @ \$20 per hour .....	\$ 6,585
Migrant council staff—	
181 hours @ \$12.50 per hour .....	2,263
Halftime (20 hours per week) @ \$2,000 per month × 5 months .....	5,000
Medical students—halftime @ \$400 per month × 4 months .....	800
Other personnel:	
Health specialist .....	2,925
Health coordinator .....	1,800
Nurse .....	2,278
Janitor .....	525
Rent .....	650
Utilities .....	90
Supplies:	
Medical .....	1,856
Maintenance .....	52
Transportation .....	130
<b>Total .....</b>	<b>\$24,954</b>

<sup>1</sup> Hospital residents hired to work part time.

The costs of both the private physicians' services and the clinics are underestimated to the extent that general administrative expenses have been omitted. No overall indirect costs were charged against the total amount of direct costs in the grant for the migrant health program. No clear costing of the

Table 3. Specific services provided migrant patients in Utah

Service	Provided by—			
	Physicians		Clinics	
	Number	Percent	Number	Percent
Prescription and medication .....	125	27	609	37
Injection .....	116	25	43	3
Laboratory tests .....	81	18	273	17
Return appointment requested .....	54	12	200	12
Counseling .....	25	5	159	10
Referral to another source of care .....	3	1	171	10
Immunization .....	11	2	88	4
Minor office surgical procedure .....	26	6	44	3
X-ray .....	14	3	46	3
Followup by clinic requested .....	2	1	18	1
Hospitalized .....	1	1	1	1
Total .....	458	101	1,652	101

<sup>1</sup> Components do not add to 100 because of rounding.

specific administrative expenses of the two systems was available. In general, the voucher system (which also was used for hospital and emergency care) required the services of a clerk to process the claims and some physician time to review them. Field workers distributed the vouchers and transported patients to the private physicians, as well as to the clinics. The clinic operation carried a much heavier administrative load, but how much of this was directly attributable to the clinical services and how much was for other aspects of the health program, such as general health education and social assistance, could not be accurately determined. Similarly, many of the administrative expenses of the central project staff, such as the salaries of the project director and his support staff, might appropriately be charged to both types of care, but again clear evidence of what proportion to assign to each was lacking. By way of reference, the total budget for the 1973 Utah migrant health program was approximately \$200,000. A safe estimate of the cost of each system of care would be about twice the cost cited.

### Discussion

A fundamental difference between the care offered by the private physicians and that provided by the clinics becomes apparent when the ratios of acute-care visits to preventive-care visits are evaluated. The ratio was nearly 4 : 1 for the private physicians, but is was only 2 : 1 for the clinics. Several philo-

sophical and economic questions should be answered before any value judgments, either for or against health maintenance, are made. Should physicians, exhaustively trained in the diagnosis and treatment of disease, "waste" their talents on well people? Does doubling the cost of care today by including health screening pay off in future savings? Or, more basically, are prevention and acute care compatible? Brown states flatly that "prevention as a point of view cannot coexist with the pressure of acute clinical activities" (3).

The gap between acute care and preventive care runs through the whole of contemporary medicine. It is expressed by the distinctions already established between clinics and private practice. The private physician is concerned primarily with treating his patients. In his professional role, he rarely seeks to promote community integration, and he is unlikely to view his function as an instrument of social change. In contrast, a clinic has the obvious option of becoming a focal point in the community for many purposes. By emphasizing preventive care and counseling services, coordination of health programs, and investigation of specific health problems, clinics can offer more than just treatment of acute illnesses. This study of the health care given migrants indicates that the clinics did offer more comprehensive services than did the private physicians, as shown by the rate of return visits, the referral rate, the percentage of visits for counseling, and the slightly greater emphasis on prevention. The data suggest that the clinics did in fact address the total care of the patient.

The difficulty of motivating migrant workers to seek preventive care is implied by the progressive decrease in visits as the reasons for seeking preventive care became less personally immediate, at least as perceived by this population. The percentages ranged from a high of 51 percent for general physical examinations, most of which were required for either employment or welfare benefits, to 22 percent for well-baby care, 16 percent for prenatal care, and 11 percent for family planning. The figures for prenatal care and family planning may reflect the multiparity of the women in this population or the religious beliefs of the people. Or perhaps they simply represent human nearsightedness—regardless of the cultural or economic situation—exacerbated by a lifestyle that makes such care a low priority amidst a struggle for existence.

Our cost data show clearly that if curative care of acute conditions is to be provided to migrant farmworkers as they request it, it is cheaper to pay for

the care through the existing health care system than to set up an alternative system. Thus, the critical question becomes whether to provide only primary care or to establish a program focused on the special health needs of migrant workers regardless of the immediate costs. On this question, consider the findings of two previous studies: Chapman found a pattern of health problems among migrants in Pennsylvania similar to the pattern we found in Utah when acute care services were offered. (4). Harkness found, however, that such chronic treatable conditions as anemia and refractive errors can also be discovered and corrected if one looks for them (5).

A coordinated health care program that includes both the delivery of acute-care services and efforts to identify and modify migrant workers' lifestyles could be easily developed from a clinic program specifically designed or oriented to cope with their special concerns. Such an approach might be concerned with the availability and quality of water for washing and drinking, pesticide exposure, or the early treatment of earaches.

Living conditions for migrant farmworkers are still extraordinarily poor, despite much publicity about their situation and some efforts to effect improvements. A survey conducted in 1969 revealed that the average migrant worker's house had only 1.9 rooms, and that nearly 96 percent did not have flush toilets, baths, or showers (6). Such conditions do not promote physical or mental well-being. Successful treatment of diseases contracted as a result of substandard housing requires attention to their causes as well as their symptoms.

Most of the issues specifically related to migrant health care remain unresolved. These concern primarily the problem of discontinuity caused by the migrant population's seasonal movement across the country. This mobility makes it difficult to establish and maintain an inexpensive data system that would make patients' clinical records available to practitioners in different locations. Nor do we know how to provide a treatment program for such chronic diseases as hypertension, congestive heart failure, or tuberculosis. Traditional curative programs, as well as preventive programs, must be adapted to the cultural and environmental constraints of the migrant population, but the challenge of adapting preventive programs is far more difficult, yet far more promising if successful. Success seems more likely in a setting that has the migrant as its primary concern.

At the same time we recognize the argument based on finite resources. Since funds are not unlimited, it

may be asked whether it is appropriate to spend money on preventive care for migrants during their peak season of employment. Might it not be more efficient to provide only curative services at this time and concentrate on preventive care when the migrants have returned to their home base? The answer to this question is more a matter of values than of facts. Those who see prevention as intimately connected with lifestyle will agree that preventive care must continually be a part of the total health care package and must therefore be available and be reinforced at all times. Our data are meant to highlight the dilemma. Put simply, one gets what one pays for. The choice of what that will be depends in large measure on societal values.

### Conclusions

This comparison of the care given migrant workers in Utah by private physicians with that provided by clinics demonstrates that clinics can provide more services and meet more of their needs. For a population group in need of an organization that can function specifically for them, the clinic offers many advantages. The clinic's role can also be expanded to become a focal point in the community for a comprehensive health care program for the disadvantaged. Although the cost of such a program may exceed the cost of traditional curative care from individual private physicians, the potential gains make it worth attempting. If long-term health is valued above short-term palliation, then the clinic would appear to be the best method of achieving this goal.

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